Mail or Fax All Forms To:
New Jersey Institute of Technology
Dean of Students and Campus Life
255 Campus Center, University Heights
Newark, NJ 07102
Website: **www.njit.edu/healthservices**
Office #: 973-596-3621 – ***Fax #:*** 973-388-2173
E-mail All Forms To: healthservices@njit.edu

HEALTH HISTORY QUESTIONNAIRE PHYSICAL EXAMINATION

TO THE STUDENT: This information is required that NJIT Student Health Services can provide care based on our particular needs. This form becomes a part of your student health record. It as well as any other health care information obtained while you are at NJIT, are confidential and will not be released to anyone without your written permission. These records must be submitted prior to or the day of registration to Health Services. If your records are not submitted within this time, a ***HOLD*** will be placed on your future registration until you provide us with your records.

FULL TIME STUDENT REQUIREMENTS:
Tuberculosis Test within the past 6 months
Of your registration *(test result is needed)*
Measles (*Proof of two doses*) after your 1st birthday
Mumps (*Proof of two doses*) after your 1st birthday
Rubella (*Proof of two doses*) after your 1st birthday
Or a serology test for Mumps, Measles, and Rubella
(a lab report is needed)
Physical Exam, by a physician (*within the past 6 months of your registration*)
Hepatitis B – Proof of 3 doses or lab report showing immunity
Varicella (Chickenpox) *(Proof of two doses*) or lab
Report showing immunity
Tdap (Given every 10 years from the last shot) required

PART-TIME STUDENT REQUIREMENTS
Same as full-time Student/No Physical Exam

MENINIGITIS B Plus MENECTRA or MENVEO VACCINE -
Required for **ALL** students.

AGE EXEMPT REQUIREMENTS
Those born before 1957 are required to submit blood test (IgG
to document immunity to Measles, Mumps, or Rubella.
It is suggested that you also be tested for immunity to
Varicella (Chickenpox). You do need to submit documentation
of all other requirements.

Check The Following: Undergraduate _______Graduate ________Full-Time______Part-Time ______EOP_______

Name: ____Date of Birth:_____/_____/_____
(Last) ***(First)*** ***(MI)***
NJIT 8 digit I.D. #______________________Phone #: (   ) ____________________ E-mail: ____________________

Permanent Home Address: ____
(Street) ***(City)*** ***(State/Country)*** ***(Zip Code)***

Campus or Local Address: ____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY

Name: ____
(Last) ***(First)*** ***(MI)***
____
(Street) ***(City)*** ***(State)*** ***(Zip Code)***

Phone Number: (______)-___________________________________E-Mail Address: ____________________________

PERMISSION FOR TREATMENT FOR STUDENT(S) UNDER 18 YEARS OF AGE. When medical problems arise, we request that the following statement be signed by a parent or legal guardian: I hereby grant permission to the physicians and practitioner of St, Michael's Medical Center/NJIT- Student Health Services to evaluate, treat, or secure a referral to an outside agency for my son/daughter/ward in case of illness/injury. I also hereby grant permission to immunize my son/daughter/ward in cases where immunization is necessary as part of a treatment plan or when needed for prevention of illness.

Parent/Guardian's Signature: ____Relationship: ____________Date: ____/____/____

PERSONAL HEALTH ASSESSMENT: For the following questions, please check yes if you are presently having a problem or have had a problem in the past. If there is no significant problem, check no. Briefly explain all yes answers. ***TO BE COMPLETED BY STUDENT.***

Drug Usage:	**Yes**	**No**
Please give information about drug usage alcohol, marijuana, smoking……………	❑	❑

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Cardiovascular:		
Heart murmur/palpitations………………….....	❑	❑
Chest Pain………………………………….	❑	❑
Rheumatic fever…………………………….	❑	❑
High blood pressure……………………….	❑	❑
Irregular heartbeat………………………….	❑	❑
Blood clots (not menstrual clots)…………..	❑	❑
Enlarge heart………………………………	❑	❑

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Respiratory:		
Asthma………………………………………	❑	❑
Chest infection………………………………	❑	❑
Do you smoke cigarettes?............................	❑	❑
How many?______How Long?________		
Shortness of breath…………………………	❑	❑
Wheezing……………………………………	❑	❑

Skin:		
Any problems with your skin?....................	❑	❑
Skin rashes…………………………………	❑	❑

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Endocrine:		
Thyroid disease…………………………….	❑	❑
Diabetes……………………………………..	❑	❑

Urinary:		
Impaired function of any part of your Urinary tract or loss of a kidney	❑	❑

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Kidney Stones:……………………………	❑	❑

Mental Health:		
Any problems with your emotional health, requiring any form of therapy, including medications?...	❑	❑
Have you ever experienced a serious dietary problem (anorexia, bulimia, obesity)	❑	❑

Medications:		
(birth control pills, vitamins, over-the counter-medications and prescriptions):	❑	❑
Amount:_____________________________		
Usage Per day:_________________________		

Past Illness:	**Yes**	**No**
Hepatitis, mononucleosis, childhood diseases, malaria………………………	❑	❑
Loss or absence of any body parts.	❑	❑
Severe/frequent colds or flu………..	❑	❑

Hospitalization:		
Have you ever been admitted to a hospital?..	❑	❑
Have you ever had surgery?...............	❑	❑

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EENT:		
Any problems with your eyes, ears, nose, or throat…………………………………	❑	❑
Hearing impairment……………………	❑	❑
Loss of eye or eyesight………………	❑	❑

Blood:		
Anemia………………………………..	❑	❑
Sickle-cell disease…………………..	❑	❑
Abnormal bleeding or bruising……..…..	❑	❑

Bone and Joint:		
Any serious disability deformity or disease of bone, joint, or muscle?...........	❑	❑

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Neurology:		
Seizures or convulsions……………	❑	❑
Fainting or blackouts………………	❑	❑
Dizziness……………………………	❑	❑

Gastrointestinal:		
Problems with any part of your intestinal tract or stomach?....................................	❑	❑
Jaundice…………………………………	❑	❑
Hernia……………………………………	❑	❑
_________________________________	❑	❑

Reproductive System (men):		
Prostate trouble…………………………	❑	❑
Swelling of the scrotum or testicle…….	❑	❑
Undescended or absent testicle………..	❑	❑
Do you perform testicular self-examination?_____________________	❑	❑

Reproductive System (women):		
Never had a menstrual period?..............	❑	❑
Any form of menstrual disorder?............	❑	❑
Do you perform breast self-exam………	❑	❑
Last menstrual period______________		

Allergy:

	Yes	No
Any significant allergy to food, medications, insects, pollen?..	❑	❑
Food? ………………………………………………………………………………	❑	❑
Other? ………………………………………………………………………………	❑	❑

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Family History:

Age and Health, if living, or Cause of Death:
Father:____
Mother:____
Brother:____
Sisters:____

Check the following diseases that have appeared among parents, grandparents, and siblings:

- ❑ Tuberculosis _________________________________
- ❑ Diabetes ____________________________________
- ❑ Cancer (type) ________________________________
- ❑ Seizure disorder ______________________________
- ❑ Stroke ______________________________________
- ❑ Heart disease _________________________________
- ❑ Kidney disease _______________________
- ❑ Emotional illness ______________________
- ❑ High blood pressure ___________________
- ❑ Problems with alcohol/drugs _____________
- ❑ Asthma _____________________________
- ❑ Other ______________________________

Comments: ____

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To The Student:

I certify that the statements in Section 1& II are true to the best of my knowledge, and I consent to treatment in the Student Health Services with the understanding that all services rendered are confidential.

Student Signature: ____ Date:________/_______/______

NJIT PHYSICAL EXAMINATION

(Completed by physician)

TO THE PHYSICIAN: Please review the student's personal history and complete the form below. Comment on all abnormal findings. This student has been accepted at New Jersey Institute of Technology and this information will note his/her medical status. It will be used only as a background for providing health care. This information is strictly for the use of the Health Services and will not be released without the written permission of the students.

Name:____Date of Birth:_____/______/_____
(Last) (First) (MI)

Height:___________________Weight______________BP_______________Pulse______________________

Vision: Uncorrected Right _____________Left_____________ Corrected Right ____________Left __________

ASSESSMENT:	Normal	Abnormal
1. Eyes …………………………………………………………………..	______	_______
2. Ears …………………………………………………………………..	______	_______
3. Nose, throat …………………………………………………………..	______	_______
4. Neck/thyroid ………………………………………………………….	______	_______
5. Chest, lungs ………………………………………………………….	______	_______
6. Cardiovascular ……………………………………………………….	______	______
7. Abdomen, liver, spleen ………………………………………………	______	_______
8. Genitalia, hernia …………………………………………………….	______	_______
9. Nervous system, balance …………………………………………..	______	_______
10. Skin ………………………………………………………………….	______	_______
11. Musculosketetal ………………………………………………………..	______	_______
Upper extremity: AC joints, shoulder stability, symmetry, range of motion		
Spine: Neck-ROM, forward bend, curve ………………………………….	______	_______
Lower extremity: range of motion, symmetry ………………………………	______	_______
Ligaments, gait, knees, ankles ………………………………………………	______	_______
12. Psychological ………………………………………………………	______	_______
13. Other …………………………………………………………………	______	_______

ABNORMAL FINDINGS:

COMMENTS: Recommendations, continuing treatment, restrictions:

____

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I have reviewed the clinical history as given by the student and after performing a physical exam, I certify that this student is able to participate in physical education and intramural activities without restrictions.

May _________________ May not ________________ Participation In _______________(Name of Sport)

Examiner's Signature ____Date _____/_____/______

Print Name ____Phone #_______________

Address ____
(Street) (City) (State) (Zip Code)